Balanced Living Acupuncture

Blanca O. Lopez, M.D.

Medical Records Request

As a patient of Balanced Living Acupuncture, LLC, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." Once received, we will use this information to verify the identity of the person making the request and then process it within the time frame proscribed by law.

Patient Name (Last, First, Middle):			
Date of Birth:	Telephone:		
Street Address:			
City:	State:	Zip:	

I, or my authorized representative, hereby authorize Balanced Living Acupuncture, LLC, to use or disclose my Personal Health Information (PHI) as designated below.

Send records to:

Name of Person or Organization:	Attention:	
Telephone:	Fax:	
Street Address:		
City:	State:	Zip:

Information to be Released:

- ☐ My complete medical record from (date) _____ to (date) _____
- ☐ My entire medical record
- ☐ Other: _____

_____

I understand this authorization is voluntary. My treatment will not be impacted if I sign the authorization or not. This authorization may include disclosure of information related to alcohol and drug abuse, sexually transmitted disease, HIV, and mental health treatment—except psychotherapy notes. Unless otherwise revoked, this authorization will expire one hundred and eighty (180) days from the date on this form. I understand that I have the right to revoke this authorization, in writing, at any time; however, By signing this form, I am confirming that it accurately reflects my wishes. I understand that if the party to which I am directing disclosure is not covered by HIPAA that my information may not be protected from further disclosure by that party.

Patient/Personal Representative/Guardian Printed Name*	Signature	Date

* If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as Power of Attorney or Guardianship papers.